

**County of San Bernardino
Department of Behavioral Health**

REQUEST TO WAIVE CONSUMER'S RESPONSIBILITY TO PAY FOR MEDICATIONS

CLINIC NAME: _____

TREATMENT STAFF: _____

CONSUMER NAME: _____

DATE: _____

CLIENT NO.: _____

ACCOUNT NO: _____

DEDUCTIBLE EXPIRATION DATE: _____

JUSTIFICATION FOR WAIVER:

A. MEDICATION PRESCRIBED AND DOSAGE

PHARMACY

COST

B. NEED FOR MEDICATION: _____

C. FINANCIAL DATA: (Attach monthly expense statement)

CONSUMER'S STATED FAMILY GROSS MONTHLY INCOME: _____

FINANCIAL INTERVIEWER'S STATEMENT ABOUT FAMILY'S GROSS MONTHLY INCOME: _____

NO. OF PERSONS DEPENDENT ON INCOME: _____

IS THERE A CURRENT FEE REDUCTION WAIVER IN EFFECT? ☐ YES ☐ NO IF YES, DATE: _____

IF NO WAIVER IN EFFECT, WILL ONE BE REQUESTED? ☐ YES ☐ NO

D. ADDITIONAL INFORMATION:

REVIEWED BY PROGRAM MGR: _____

☐ APPROVED DATE: _____ SIGNATURE: _____

☐ DISAPPROVED DATE: _____ SIGNATURE: _____

REASON: _____

REVIEWED BY PROGRAM MGR: _____

☐ APPROVED DATE: _____ SIGNATURE: _____

☐ DISAPPROVED DATE: _____ SIGNATURE: _____

REASON: _____

REVIEWED BY PROGRAM MGR: _____

☐ APPROVED DATE: _____ SIGNATURE: _____

☐ DISAPPROVED DATE: _____ SIGNATURE: _____

REASON: _____

IF APPROVED, THIS FORM IS VALID FOR 6 MONTHS OR UPON FI EXPIRATION DATE. EXPIRATION DATE IS: _____